



Utah Department of Health  
Office of Primary Care & Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
<http://health.utah.gov/primarycare>

## NURSE SCHOLARSHIP APPLICATION

### UTAH HEALTH CARE WORK FORCE FINANCIAL ASSISTANCE PROGRAM

PLEASE PRINT

Page 1 of 13

*The Utah Health Care Work Force Financial Assistance Program is administered without regard to race, color, religion, national origin, sex, age, or status as a handicapped individual or disabled veteran.*

Scholarships are Available for Graduate Nursing Degree's  
for Individuals that will be Nurse Educators/Instructors  
Upon Completion of Schooling ONLY.  
Degree Sought: ☐ MSN ☐ PhD  
Please specify specialty, if any:  

---

(i.e., NP, CNM, CRNA, Psychiatric Nurse Specialist)

#### Section I Personal Information

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Your Specialty: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (Apartment/Suite Number)

\_\_\_\_\_  
(City) (State/Province) (Country) (Zip Code)

Telephone Number: HOME:( ) WORK:( )

Email Address: \_\_\_\_\_ FAX:( )

Social Security Number: \_\_\_\_\_

Place of Birth: \_\_\_\_\_  
(City) (State/Province) (Country)

Are you a citizen or permanent resident of the United States? Yes ☐ No ☐

Are you fluent in any language other than English? Yes ☐ No ☐

If Yes, please specify: \_\_\_\_\_

Describe, in one page or less, your personal and cultural experiences with underserved populations:

---

---

If you need additional space to answer any of the questions in this application,  
please limit your response to one page per section,  
and print your name and social security number at the top of each page.

PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 2 of 13

**Section I: Personal Information (continued)**

***Optional Items***

Birth Date: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status:      Single ☐      Married ☐      Divorced ☐      Widowed ☐

If Married, Full Name of Spouse: \_\_\_\_\_

Children:              Yes ☐      No ☐

**Section II**

**Education**

**1. *Undergraduate Education***

Name of Institution: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
\_\_\_\_\_

Begin Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Month/Year                                      Month/Year

Degree(s) Obtained: \_\_\_\_\_

**2. *Other Undergraduate Education***

Name of Institution: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
\_\_\_\_\_

Begin Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Month/Year                                      Month/Year

Degree(s) Obtained: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**

November 2003    F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 3 of 13

**Section II Education (continued)**

3. **Graduate** (other than school listed in Section II, Number 4)

Name of Institution: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
\_\_\_\_\_

Begin Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Month/Year Month/Year

Title of Degree Obtained: \_\_\_\_\_

Academic Specialty: \_\_\_\_\_

Program Director: \_\_\_\_\_

4. **Graduate Program in which you have been accepted, and for which you are requesting scholarship funding.**

Name of Institution: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
\_\_\_\_\_

Begin Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Month/Year Month/Year

Will you attend: Full-Time? ☐ Part-Time? ☐ Average credit load per semester/quarter: \_\_\_\_\_

Academic Specialty: \_\_\_\_\_

Program Director: \_\_\_\_\_

**Official transcripts for all Undergraduate and Graduate institutions listed previously  
must be sent with this application.**

**ALSO, a copy of your letter of acceptance into the graduate program must be included.**

**Section III**

**Professional Experience**

PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 4 of 13

1. Employment History: Provide name and contact information of the director or official of each site where you have practiced in the last five years:

a. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
(Complete Site Name)

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Allocation of Time (Hours per week):

Clinic Care: Administration: \_\_\_\_\_ Clinical/Practice Based: \_\_\_\_\_ Hospital Based: \_\_\_\_\_

Teaching: \_\_\_\_\_ Other (Specify): \_\_\_\_\_

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Month/Year Month/Year

Duties: \_\_\_\_\_

b. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
(Complete Site Name)

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Allocation of Time (Hours per week):

Clinic Care: Administration: \_\_\_\_\_ Clinical/Practice Based: \_\_\_\_\_ Hospital Based: \_\_\_\_\_

Teaching: \_\_\_\_\_ Other (Specify): \_\_\_\_\_

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Month/Year Month/Year

Duties: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**



PLEASE PRINT

Page 5 of 13

**Section III Professional Experience (continued)**

4. List states in which you currently hold, or have held, a nursing license (**Note: You must be eligible to obtain an unrestricted license to practice in the State of Utah.**)

\_\_\_\_\_

5. License classification (State of Utah):\_\_\_\_\_

If you are exempted from licensure, please state reasons(s):\_\_\_\_\_

\_\_\_\_\_

6. Have you ever been subject to any disciplinary action or licensure restrictions? Yes ☐ No ☐

If Yes, by whom (Please Explain):\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Certifications (if any):

Certification in:\_\_\_\_\_ Issued by:\_\_\_\_\_ When?\_\_\_\_\_ month/year

Certification in:\_\_\_\_\_ Issued by:\_\_\_\_\_ When?\_\_\_\_\_ month/year

If not yet certified, will you be taking a certifying exam? Yes ☐ No ☐

In what specialty?\_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 6 of 13

**Section III Professional Experience (continued)**

***Other Training***

Describe any other pertinent training (Include experience with underserved populations):

1. Location: \_\_\_\_\_  
(Business Name)

Name of Supervisor/Director: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Complete Address: \_\_\_\_\_  
(Complete Business Name)

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Month/Year Month/Year

Describe Experience: \_\_\_\_\_

2. Location: \_\_\_\_\_  
(Business Name)

Name of Supervisor/Director: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Complete Address: \_\_\_\_\_  
(Complete Business Name)

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Month/Year Month/Year

Describe Experience: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 7 of 13

**Section IV**

**Professional References**

Please list **THREE (3)** professional references knowledgeable about your academic qualifications.

1. Reference Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

2. Reference Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

3. Reference Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

**Section V**

**Personal References**

Please give the names and addresses of **THREE (3)** persons, not related to you by blood or marriage, who are qualified to give information regarding your character or financial need.

1. Reference Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 8 of 13

**Section V Personal References (continued)**

2. Reference Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

3. Reference Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

**Section VI Loan Repayment or Scholarship Service Commitments**

1a. Do you have any existing service obligations? Yes ☐ No ☐

If Yes, Name of Program: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Contract Entity: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Terms of obligation: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd





PLEASE PRINT

Page 9 of 13

**Section VI Loan Repayment or Scholarship Service Commitments (continued)**

1b. Are you in default of this or any other obligation? Yes ☐ No ☐

If Yes, describe circumstances: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Will your employer provide a tuition/reduction waiver? Yes ☐ (\_\_\_\_\_% ) No ☐

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Will you receive, from any other private or public entity, a tuition/education waiver? Yes ☐ (\_\_\_\_\_% ) No ☐

If yes, please provide the name of the entity(ies) and explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. How many years of service are you willing to commit? 2 years ☐ 3 years ☐ 4 years ☐

5. Please list any other competencies or awards not referred to in this application:

\_\_\_\_\_

\_\_\_\_\_

**Section VII**

**Essay**

1. In no more than 300 words, describe **each** of the following: a) your reasons for desiring to pursue graduate nursing education, b) your short as well as long-term career goals; and c) how a scholarship provided to you would benefit the State of Utah.

Please include a copy of your curriculum vitae and State of Utah license along with this application.

**Section VIII**

**Scholarship Budget**

PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd



PLEASE PRINT

Page 10 of 13

1. Academic period for which you are requesting the scholarship:

From: \_\_\_\_\_ To: \_\_\_\_\_  
(month/year) (month/year)

Number of Semesters or Quarters: \_\_\_\_\_

Please provide an estimate of your total educational expenses for the time period noted above, as well as the amount that you are requesting to have paid by the Program (for example tuition and fees only, tuition, fees and reasonable living expenses, etc.). Note that the Program will consider only those educational expenses that you expect to incur from the time you submit your application. "Educational expenses" mean the cost of education to obtain a masters or doctorate in nursing, including tuition, fees, books, supplies, educational equipment and materials, and reasonable living expenses.

	Total Expenses	Amount You Are Requesting to Have Paid by the Program
a. Tuition	\$	\$
b. Fees	\$	\$
c. Books	\$	\$
d. Supplies	\$	\$
e. Educational Equipment and Materials	\$	\$
f. Reasonable Living Expenses *	\$	\$
Transportation Expenses Related to your Education	\$	\$
<b>TOTALS</b>	<b>\$</b>	<b>\$</b>

\* List the type(s) of *reasonable* living expenses you would like the Program to consider (transportation expenses should be listed separately). Note that the Program will not consider items such as home equity or car loans, credit card balances, tuition for children or spouse, or items listed as miscellaneous.

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**

November 2003 F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Provider\nurseSCH11-03.wpd





Utah Department of Health  
Office of Primary Care & Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
<http://health.utah.gov/primarycare>

## NURSE SCHOLARSHIP APPLICATION

### UTAH HEALTH CARE WORK FORCE FINANCIAL ASSISTANCE PROGRAM

PLEASE PRINT

Page 12 of 13

### INFORMATION RELEASE

I Am Applying for an Educational Loan Repayment or Scholarship Grant Through the Utah Health Care Workforce Financial Assistance Program.

I Consent to the Release to the Utah Department of Health Private, Sensitive, Privileged, and Otherwise Confidential Information about Me to the Extent That it Bears upon Any of the Following: My Education; Internship, Postgraduate, Preceptorship, or Residency Speciality Training; Board Certification; Experience; Professional Conduct; Ethics; Ability to Work with Others; Hospital and Other Affiliations; Disciplinary Actions; Malpractice Claims History; Litigation Experience; State Licensure; and Controlled Substance Licensure. I Intend That this Consent Include All Information That Reflects on My Ability to Safely, Competently, and Professionally Perform the Professional Activities Required of Me Should I Receive a Grant or Scholarship under this Program.

I Intend That this Consent Extend to All Persons, Institutions, and Entities That Have Such Information about Me, Including: Colleges, Universities, Professional Societies, Hospitals, Speciality Boards, Practice Groups, Clinics, Insurance Companies, Partnerships, Professional Corporations, and Employers, and to Persons and Committees Associated with Any of These. I Also Give My Consent for All Such Persons, Institutions, and Entities to Express Their Evaluation of Me and Make Recommendations about My Professional Skill, Conduct, and Ability to Perform Clinical Duties in the Area for Which I Have Applied.

I Intend That a Copy of this Document May Be Relied upon as If it Were the Original.

Legal Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_  
(Type or Print Clearly)

Social Security Number of Applicant: \_\_\_\_\_  
(Type or Print Clearly)

#### **Warning**

Any Person Who Knowingly Makes a False Statement or Misrepresentation in this Scholarship Application, Fraudulently Obtains Scholarship Funds, or Commits Any Other Illegal Action in Connection with this Transaction Is Subject to a Fine or Imprisonment. I Have Read this Statement and Understand its Contents.



PLEASE PRINT

Page 13 of 13

### Check List:

Have You Included Each of the Following?  
If Not, Your Application May Be Delayed or Denied.

Please Assure That Each of the Boxes below Are Checked and this Check List Is Returned with Your Completed Application.

- ☐ Have All Sections of the Scholarship Application Been Completed? Sections "Not Applicable" Should Have Been Marked "Na." If Not, Your Scholarship Application May Be Delayed or Denied.
- ☐ Submit a **Completed** Application for Educational Scholarship to the Utah Department of Health, Including:
  - a. personal Information and
  - b. certification.
- ☐ A Copy of Your Curriculum Vitae **must** Be Included in Your Application.
- ☐ A Copy of Your Official Transcripts for All Undergraduate and Graduate Institutions Listed in this Application **must** Be Submitted with this Application.
- ☐ A Copy of Your Letter of Acceptance into the Graduate Program **must** Be Included in Your Application.
- ☐ Be a Nurse Who Has a License in Good Standing to Practice in the State. You **must** Provide a Copy of Your Current, Unrestricted License to Practice Nursing in the State of Utah.
- ☐ The required 300 word Essay **must** be included with this Application.
- ☐ The Information Release Form of this Application **must** Be Signed and Dated.
- ☐ Submit All Documentation Together. Incomplete Applications Will Be Returned. When All Materials Have Been Submitted, Funding Priority Will Then Be Assigned.
- ☐ Complete Applications must Be Submitted by the Following Due Date: **December 31, 2003**. Applications Not Received by the Due Date Will Not Be Processed.

Note: Loan repayment and Scholarship grants are subject to federal, state, and local taxes.  
If you have additional questions, please consult a tax professional.